



PRIVATIZATION IN DENTAL HEALTH EDUCATION AND HEALTH CARE SYSTEMS - THE INDIAN SCENARIO

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ABSTRACT

Privatization is the transfer of ownership, property or business from the government to the private sector. It is considered to bring more efficiency and objectivity to the company, something that a government company may not be concerned about. The field of oral health care has been one among the most potential areas of implementation of this concept of 'privatization', the reasons being the rigidity of public institutions and their inability to change or adapt to different stimuli from the environment, including populations' and patients' expectations. The frequent opinion that all private structures per se function more efficiently and more productively is nothing but a statement; this applies well to many private dental health care setups with regards to comprehensive health care of each patient and oral health education. Problems such as imbalanced specialist training, and inequity of access to dental care because of dentists being more concentrated in cities and towns is the current Indian scenario.

This article reviews the various limitations and problems encountered in dental health care in India and the possible solutions to these.

KEYWORDS: Privatization, dental health care, dental health education.

INTRODUCTION

Privatization of health care can be evaluated through the assessment of 'quality of health services'. This does not include only positive effects. The most frequently seen negative effects is that the vulnerable population does not receive equal access to quality services.¹

The field of oral health care has been one among the most potential areas of implementation of this concept of 'privatization', the reasons being the rigidity of public institutions and their inability to change or adapt to different stimuli from the environment, including populations' and patients' expectations. However, the frequent opinion that all private structures per se function more efficiently and more productively is just a statement.

The reasons for this might be (1) challenges to equity when introducing personal expenditures in setting up private dental health care setups and (2) risk of development of a health care system available to those with a better ability to pay and directed mainly to offering services instead of a comprehensive management which includes health education.

Education is the driving force of economic and social development in any country.² Private initiatives in health education were initially for philanthropic reasons, but over time, the goals have changed and quality of health education seems to be compromised in many institutions. This has resulted in the production of a health workforce in India with an increasing tendency towards profit-oriented practice, and the real health needs of the society still remain unmet.

This article reviews the problems in the dental health education and health care systems in India, the mistaken goals of privatization and the possible remedies to these.

THE CURRENT SCENARIO OF HEALTHCARE IN INDIA

India is the seventh largest country in the world. The population in India has risen from 850 million in 1990 to 1.252 billion in 2013 and much beyond by the end of 2015. Though efforts have addressed numerous issues and much progress can be reported, the gap between the aspiration - of providing quality healthcare on an equitable, accessible and affordable basis across all regions and communities of the country, and today's reality is all too apparent.

The three-tier healthcare system in India includes, at the lowest level, primary health centres (PHCs), one in each community development block, which were designed to provide basic medical care, disease prevention, and health education. The next tier, sub-centres (SCs) were intended to provide public health services. A top tier of community centers and district hospitals offers specialist services.

There are no set criteria for posting a dentist at the primary level (PHC). Community health centres (CHCs) have one post for a dental surgeon, but none for a dental specialist. Oral health policy was drafted by the Dental Council of India (DCI)

in 1985. The National Oral Health Policy, 1985 recommends public health dentists to be appointed at primary and community health centres. Till today, the policy has not been implemented.³ Many surveys show that both urban and rural Indian households tend to use the private health sector more frequently than the public sector.

THE PROBLEMS...

India has around 300 dental colleges, which makes approximately about one-third of the dental schools present worldwide.⁴ Such a large number of dental schools has resulted in an increasing number of dentists graduating each year.

What is likely to be expected is that this large number of graduating dentists will address the issue of shortage of dentists in India. However, the current scenario is quite different.

1. Lack of adequate infrastructure in many dental schools running across the country
2. Imbalanced specialist training, with an increasing demand for pediatric dentists and public health dentists.
3. Inequity of access, dentist-population ratio being 1:9000 dentists in metros/urban and semi urban areas and 1:2,00,000 dentists in the rural areas. Dentists tend to prefer large towns or cities to smaller towns and rural areas for establishing their practice as charges for dental health care can be set at a higher scale and a greater inflow of patients who have a better ability to pay for the 'so called services' offered.
4. Poor job opportunities and subsequent migration to other countries.⁵
5. Insufficient numbers of dental auxiliaries.
6. Defects in the quality of dental education, with lack of sufficient interdisciplinary interaction.

WHAT CAN BE DONE

- The ultimate responsibility for the performance of a country's health system lies with the government. Mobilization of more funds from the centre towards health care and especially inclusion of oral health care in public health policies is the need of the hour. Dental healthcare personnel need to be appointed in government run primary and community health centers.
- Not for profit private organizations need to be encouraged to set up dental healthcare facilities in under privileged areas.
- Community outreach clinics with adequate facilities should be set up by dental colleges in rural areas and dental specialists as well students should be

posted in these outreach centers on a regular basis. Care should be taken that these centers have adequate facilities. This will expose the dental students to needs of those patients, help them to attain necessary competence in comprehensive management of patients under the guidance of qualified specialists, and help them to appreciate the limits of their own skills and the circumstances where referral to a specialist becomes necessary.⁶

CONCLUSION

Privatization of health services, especially dental health services can prove to be boon to health care if certain issues like unequal distribution of funds and defects in the quality of dental health education are corrected. The responsibility lies in the hands of the Government, the public and dental health personnel. The Government has to allocate more budget towards oral health care, and private organizations need to hold hands with NGOs in utilizing these funds wisely. We live in a democratic nation, where we form the Government and changes should thus happen first in our attitudes and our understanding of the current status of oral health care in India and our responsibility in what is needed to bring about the change.

REFERENCES

1. SaltmanRB, Figueras J. European Health Care Reform: Analysis of Current Strategies. Copenhagen : WHO Regional Office for Europe. 1997
2. Cholin VS. Study of the application of information technology for effective access to resources in Indian university libraries. The International Information & Library Review 2005; 37(3):189-197
3. National oral health policy: Prepared by core committee, appointed by Ministry of Health and Family Welfare, 1985
4. Singh A, Purohit B. Fracas over privatization, quality assurance and corruption in Indian higher education. Journal of Education and Practice 2011; 2(11,12):50-59
5. Tandon S. Challenges to the oral health workforce in India. Journal of Dental Education July 2004; 68(7): 28-33.
6. Holbrook et al. balancing the role of the dental school in teaching, research and patient care; including care for undeserved areas. European Journal of Dental Education 2008;12(1):161-166